

Davis-Besse

3Q/2005 Plant Inspection Findings

Initiating Events

Significance: SL-IV Jun 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

INACCURATE/INCOMPLETE INFORMATION (BY OMISSION) IN LER 05000346/1997-004

A self-revealing issue was identified, during preparations for an NRC inspection, when the licensee discovered that Licensee Event Report (LER) 05000346/1997-004 was not complete and accurate in all material respects. Specifically, information had been removed from the LER prior to issuance. The deleted information was considered to be material by the NRC because if it had been complete and accurate, it would have resulted in additional inspection activities in the area of the completeness of corrective actions associated with this issue. Subsequent to the discovery of the deficiency, the licensee submitted Revision 01 to LER 05000346/1997-004, on March 26, 2004, which documented the originally omitted information. Because the issue affected the NRC's ability to perform its regulatory function, this finding was evaluated with the traditional enforcement process. Following a review of the additional information, inspectors determined that licensee corrective actions to address the material conditions documented in the original LER were sufficient. This issue was determined to be a Severity Level IV Non-Cited Violation, consistent with Section VI.A.1 of the NRC Enforcement Policy, of 10 CFR 50.9.

Inspection Report# : [2005007\(pdf\)](#)

G

Significance: Mar 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

UNANTICIPATED PLANT RESPONSE TO LARGE BORIC ACID ADDITION TO RCS

A finding of very low safety significance was self-revealed when the control room operators did not demonstrate conservative actions when they failed to fully anticipate the plant response to a large boric acid addition to the reactor coolant system, which was conducted as part of the planned de-boration of number 2 mixed bed demineralizer. The resulting transient caused the controlling control rod group to move to its full out position and required operator to take manual action to decrease the Unit Load Demand until all of the demineralized water was added, which allowed the control rod index to return to normal position, and power was reduced approximately 1.5 percent as a result of this action. The primary cause of this finding was related to the cross-cutting area of Human Performance because the control room operators failed to operate the plant in a controlled manner, as required by plant procedures. The inspectors determined that the finding was more than minor because it directly involved the human performance attribute of the Initiating Events cornerstone's objective which is to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The finding was of very low safety significance because the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available if called upon. This issue was a Non-Cited Violation of Technical Specification 6.8.1, which required, in part, to establish and implement procedures that provide guidance on authorities and responsibilities for safe operation and shutdown of the reactor plant.

Inspection Report# : [2005005\(pdf\)](#)

Mitigating Systems

G

Significance: Sep 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

SCAFFOLDING ERECTED CLOSER TO SAFETY RELATED EQUIPMENT THAN PERMITTED & W/O PROPER DOCUMENTATION OF REVIEWS

A finding of very low safety significance was identified by the inspectors when the licensee failed to properly implement existing procedural guidance for the control of gaps between scaffolding and plant equipment and failed to properly review and document the scaffolding installation. Scaffolding was erected less than one inch from safety-related containment spray instrumentation lines and high pressure injection pump lube oil piping. The scaffolding was constructed in this manner even though there were no physical interferences which necessitated that the scaffolding to be erected with less than the procedurally permitted one inch gap. Additionally, rationale for approval of the configuration was not provided as was procedurally required. Once identified, the licensee took prompt action to review the scaffolding installation and modify the scaffolding to conform to a procedurally allowed configuration. The improperly approved scaffolding was in place approximately eight hours. The finding was more than minor since it was associated with the attributes of protection against external factors and configuration control and affected the mitigating systems' objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors determined that the finding was of very low safety significance because there was

no actual loss of function of any of the plant safety-related systems due to the placement of the scaffold. This issue was determined to be a Non-Cited Violation of 10 CFR 50, Appendix B, Criterion V. The primary cause of this violation was related to the cross-cutting area of Human Performance because licensee personnel, while having adequate procedural guidance, failed to implement the requirements of that guidance.

Inspection Report# : [2005008\(pdf\)](#)

Significance:  Aug 12, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO INITIATE A CONDITION REPORT FOR CONDITIONS ADVERSE TO QUALITY

The inspectors identified a Green Finding associated with a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the failure to properly implement procedure NOP-LP-2001, "Condition Report Process." The item involved the failure to initiate condition reports for failures, malfunctions, or deficiencies identified in nuclear safety related equipment. The inspectors identified seven occurrences where licensee personnel failed to initiate a condition report for conditions adverse to quality during the period November 1, 2004, to August 1, 2005. The inspectors determined that the failure to initiate condition reports for the specific examples of conditions adverse to quality was greater than minor because if left uncorrected the issue would become a more significant safety concern involving programmatic and equipment issues. The inspectors determined that the finding was not suitable for SDP evaluation because the failure to initiate the condition reports did not directly result in degraded or inoperable equipment. Therefore, this finding was reviewed by Regional Management, in accordance with IMC 0612 Section 05.04c, and determined to be of very low safety significance.

Inspection Report# : [2005014\(pdf\)](#)

Significance:  Aug 08, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Implement Plant Modification into Emergency Procedure (Section 40A4.1)

Green. A Green finding associated with a Non-Cited Violation of Title 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was self-revealed for the failure to remove an abandoned equipment load listed in the Emergency Procedure DB-OP-02000 as part of modification MOD 95-0050. As a result, upon implementation of the modification, the licensee failed to identify the component abandoned by the modification was referenced in the plant emergency procedures. On July 20, 2005, the inspectors observed operators perform Job Performance Measure (JPM), 2005 NRC JPM F, in the simulator during the NRC initial license examination. The inspectors noted that the applicants had difficulty completing the required procedural steps because of a delay in reducing the load on the electrical bus.

The inspectors determined that a primary cause of this finding was related to the cross-cutting area of Human Performance because the licensee failed to verify the appropriate emergency procedure revisions were established based on the equipment modification.

Although simulated as part of an NRC operator license examination, the issue was more than minor because the finding was associated with the configuration control attribute of the Mitigating Systems cornerstone and adversely impacted the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors evaluated the finding using IMC 0609, Appendix A, Phase 1 Screening, "Secondary Core Decay Heat Removal Degraded." The inspectors also determined that the finding was of very low safety significance because even though the establishment of feedwater flow to the Once Through Steam Generator (OTSG) was delayed, the applicants did complete the task as assigned and would have been able to start the Motor Driven Feedwater Pump (MDFP). The licensee took prompt action to enter the item into their corrective action process. (Section 40A4)

Inspection Report# : [2005301\(pdf\)](#)

Significance:  Jun 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

INOPERABILITY OF EMERGENCY BATTERY PACKS AND ASSOCIATED LIGHTING CREDITED WITH LICENSEE COMPLIANCE TO 10 CFR 50, APPENDIX R, SECTION III.J

A finding of very low safety significance was identified by the inspectors which was a violation of 10 CFR 50, Appendix R, Section III.J. The licensee failed to identify the loss of power to four emergency battery packs and associated lights for a period of time which exceeded eight hours and which existed for a period of potentially up to eight days. The battery packs and lights were used by the licensee to show compliance with 10 CFR 50 Appendix R, Section III.J. Once identified, the licensee promptly re-energized the charging circuit. The primary cause of this violation was related to the cross-cutting area of Problem Identification and Resolution because licensee personnel had multiple opportunities to question the loss of lighting in an area frequented by plant personnel which was caused by de-energization of the same circuit that provided power to the emergency battery pack charging circuit. Once identified, the licensee promptly restored the lights. The finding was more than minor because the issue affected the reliability objective and equipment performance attribute of the mitigating systems cornerstone. The finding was of very low safety significance because the discharged emergency battery packs and associated lighting represented a low degradation of the emergency lighting element of the fire protection program.

Inspection Report# : [2005007\(pdf\)](#)

G**Significance:** May 06, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Procedure Places Air Void in Suction to MDFP When Aligned to Service Water

The inspectors identified a Non-Cited Violation of Technical Specification 6.8.1, "Procedures and Programs," regarding an inadequate procedure related to transferring the suction source for the motor-driven feedwater pump from the condensate storage tank to the backup service water supply. Specifically, implementation of the procedure would have placed a significant quantity of air into the suction piping for the pump, potentially degrading the pump or making it inoperable. The licensee initiated an operations standing order to adequately fill the affected section of piping prior to transferring the suction supply.

The issue was more than minor because it was associated with the attribute of equipment performance, which affected the mitigating systems cornerstone objectives of ensuring the availability, reliability, and capability of systems and components that respond to initiating events. The finding is of very low safety significance based on the results of the SDP Phase 1 screening worksheet.

Inspection Report# : [2005004\(pdf\)](#)**G****Significance:** May 06, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Battery Cell Float Voltage Less Than Tech Spec Minimum of 2.13 Volts

The inspectors identified a Non-Cited Violation of Technical Specifications Table 4.8-1 for the failure to identify that a battery cell float voltage reading was below the required 2.13 volts minimum value. Based on Table 4.8-1, note (2), this required an action (i.e. equalize charge) within 7 days to restore the voltage such that the battery would remain operable, which was not accomplished. This was considered a past operability issue. Subsequent readings on the battery cell were within the Technical Specification required value, which addressed present operability concerns.

This finding was more than minor because it was associated with the attribute of human performance, which affected the mitigating systems cornerstone objective of ensuring the availability and reliability of the DC power system to respond to initiating events to prevent undesirable consequences. The human performance finding also had a cross-cutting aspect because the licensee failed to identify a voltage reading that did not meet acceptance criteria during the surveillance. The finding is of very low safety significance based on the results of the SDP Phase 1 screening worksheet.

Inspection Report# : [2005004\(pdf\)](#)**G****Significance:** May 06, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Electrical Isolation When Using a Single Cell Battery Charger

The inspectors identified a Non-Cited Violation of Technical Specification 6.8.1, "Procedures and Programs," regarding an inadequate maintenance procedure related to battery charging. Specifically, the maintenance procedure did not ensure that adequate electrical isolation was maintained when a non-Class 1E single cell battery charger was used to charge a single battery cell.

This finding was more than minor because it was associated with the attribute of equipment performance, which could have affected the mitigating systems cornerstone objective of ensuring the availability and reliability of the DC power system to respond to initiating events to prevent undesirable consequences. The finding is of very low safety significance based on the results of the SDP Phase 1 screening worksheet.

Inspection Report# : [2005004\(pdf\)](#)**G****Significance:** Mar 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

LICENSEE'S DECAY HEAT SYSTEM RESTORATION FROM PLANNED MAINT PERMITTED FORMATION OF AIR VOID IN DECAY HEAT LINE FROM RCS TO DECAY HEAT PUMP #2

A finding of very low safety significance was self-revealed when licensee personnel, during review of the configurations of decay heat piping, determined that recent system restoration from the decay heat pump 2 seal refurbishment was not adequate to prevent the formation of an air void in the decay heat line from the reactor coolant system to the decay heat pump 2. An air void in the line could impede operator's efforts to establish decay heat cooling and, if required, post loss of coolant accident boron precipitation control using the decay heat system. The primary cause of the finding was related to the cross cutting area of Human Performance because the preparers and reviewers of the system clearance for the pump seal refurbishment failed to identify that the vent path specified in the system restoration was not the high point of the piping that had been drained and that another vent path could be made available that would have precluded an air void formation in the piping during system refill. The inspectors determined that the finding was more than minor because it directly involved the human performance attribute of the Mitigating System cornerstone's objective which is to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding was of very low safety significance because the finding did not result in any actual loss of safety function and did not screen as significant using the criteria as outlined in the mitigating system section of the Phase 1 significant determination worksheet. This issue was a Non-Cited Violation of Technical Specification 6.8.1, which required, in part, the development and

implementation of procedures that provide guidance on equipment control and instructions for filling and venting the decay heat cooling system.

Inspection Report# : [2005005\(pdf\)](#)

Significance: **G** Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

UNTIMELY CORRECTIVE ACTIONS TO CORRECT SAFETY-RELATED BATTERY TERMINAL CONNECTION CORROSION

The inspectors identified a finding of very low safety significance for the licensee's failure to take timely corrective action to remove visible corrosion on several terminal connections on the station's safety-related 2P and 2N batteries. The primary cause of this finding was related to the cross-cutting area of problem identification and resolution. The inspectors determined that the finding was more than minor because it impacted the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. This issue was determined to be of very low safety significance because there were no documented cases of any of the affected battery cell's terminal resistance measurements in excess of 150 micro-ohms. This was considered to be a Non-Cited Violation of 10CFR 50, Appendix B, Criterion XVI.

Inspection Report# : [2004016\(pdf\)](#)

Significance: **G** Dec 16, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO INITIATE A CONDITION REPORT FOR CONDITIONS ADVERSE TO QUALITY IN THE AUXILIARY FEEDWATER SYSTEM

The inspectors identified a finding of very low significance associated with a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings, for failure to initiate a condition report for conditions adverse to quality in the auxiliary feedwater system. The inspectors identified two conditions adverse to quality that had not been entered into the corrective action program. The inspectors determined that the failure to initiate condition reports for conditions adverse to quality in the auxiliary feedwater system was greater than minor because if left uncorrected the issue would become a more significant safety concern involving programmatic and equipment issues. The inspectors determined that the finding was not suitable for SDP evaluation because the failure to initiate the condition reports did not directly result in degraded or inoperable equipment. Therefore, this finding was reviewed by Regional Management, in accordance with IMC 0612 Section 05.04c, and determined to be of very low safety significance.

Inspection Report# : [2004017\(pdf\)](#)

Significance: **G** Dec 16, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY AND EFFECTIVELY CORRECT DEGRADATION OF UNDERGROUND CABLES DUE TO WATER INTRUSION

The inspectors identified a finding of very low significance associated with a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for the failure to assure that adequate and timely actions were promptly identified and implemented to address several underground wetted cable issues, a condition adverse to quality. This inspector-identified issue was greater than minor because if left uncorrected, the issue could become a more significant safety concern and could affect the mitigating systems attributes of equipment performance reliability. The inspectors evaluated the finding using Inspection Manual Chapter 0609, "Significance Determination Process," Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," Phase 1 screening. The inspectors determined that the finding (1) did not result in a design or qualification deficiency confirmed to result in a loss of function per NRC Generic Letter 91-18; (2) did not represent an actual loss of safety function; (3) did not result in a loss of safety function of a single train for greater than the Technical Specification allowed outage time; (4) did not represent an actual loss of safety function of one or more non-Technical Specification trains designated as risk significant per the Maintenance Rule for greater than 24 hours; and (5) did not screen as potentially risk significant due to seismic, fire, flooding, or severe weather initiating events.

Inspection Report# : [2004017\(pdf\)](#)

Significance: **SL-IV** Nov 13, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM APPROPRIATE 50.59 SCREENING CONCERNING ECCS SUMP PUMP AFFECT ON ECCS COMPONENT OPERABILITY

A failure to perform an adequate safety evaluation review as required by 10 CFR 50.59 for changes made to the facility as described in the Updated Safety Analysis Report (USAR) was self-revealed. In June 2003, the licensee changed the limit and precautions sections of several procedures to specify that emergency core cooling system (ECCS) room sump pumps were not required to be in service for ECCS and containment spray equipment operability. However, the USAR credits the ECCS sump pumps and their running lights for providing indication of the need for operator action in response to a passive failure in the ECCS system. The procedure changes were inappropriately categorized as being exempt from the 50.59 process because the changes involved "Managerial or Administrative Procedures." Because the issue affected the NRC's ability to perform its regulatory function, this finding was evaluated with the traditional enforcement process. The finding was

determined to be of very low safety significance because, although the procedure changes could have resulted in the operation outside the requirements of technical specification action statements, no loss of function occurred. This was determined to be a Severity Level IV NCV of 10 CFR 50.59.

Inspection Report# : [2004015\(pdf\)](#)

Significance:  Nov 13, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO COMPLY WITH TS REQUIRED PROCEDURES FOR CONTROL OF STATUS OF CCW 1 BREAKER WHILE DANGER TAGGED

A finding of very low safety significance was self-revealed when maintenance personnel failed to adhere to the requirements of administrative work control documents and instructions during maintenance activities associated with the racking in of breaker AC113 [CCW 1 Motor Supply Breaker]. With a danger tag hanging on the breaker cubicle door, licensee personnel installed the breaker into the breaker cubicle with the intention of operating the breaker to perform maintenance checks on the CCW pump 1 motor. This was contrary to licensee's procedural requirements. The inspectors concluded that the finding was more than minor because, if left uncorrected, it could become a more significant safety concern. Specifically, the operation or manipulation of the danger tagged AC-113 breaker could have resulted in equipment damage or serious personnel injury. This issue was determined to be of very low safety significance because there was no maintenance evolutions in progress on the CCW 1 pump motor which would have required the breaker AC-113 to be racked out at the time of the breaker was inappropriately racked into its cubicle. This was determined to be a Non-Cited Violation of Technical Specification 6.8.1.a.

Inspection Report# : [2004015\(pdf\)](#)

Significance:  Jan 07, 2004

Identified By: NRC

Item Type: VIO Violation

Failure to Take Corrective Actions for a Previous NCV Concerning SW Discharge Path Swapover Setpoints

The team identified a Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control." Specifically, the licensee failed to provide a basis for the setpoint to swap the service water system discharge path. This issue was previously identified as a Non-Cited Violation in Inspection Report 05000346/2002014 and the corrective actions taken by the licensee failed to correct the originally identified condition. The primary cause of this violation was related to the cross-cutting areas of problem identification and resolution and human performance, because the licensee did not recognize that the corrective actions taken needed to restore compliance with the identified violation of NRC requirements.

The issue was determined to be more than minor because the licensee had not corrected a previous violation and was relying on non-safety-related equipment to perform a safety function under design bases conditions. Because the issue was previously determined to be of very low safety significance, NRC management concluded that the violation could be categorized as having very low safety significance. (Section 40A3(3)b.11)

Inspection Report# : [2003010\(pdf\)](#)

Significance:  Jan 07, 2004

Identified By: NRC

Item Type: VIO Violation

Failure to Take Corrective Actions for a Previous NCV Concerning SW Pump Discharge Check Valve Acceptance Criteria

The team identified a Cited Violation of Technical Specifications Section 4.05a and 10 CFR 50.55a. Specifically, the licensee failed to ensure that the service water discharge check valve was tested in accordance with the American Society of Mechanical Engineers Code. The primary cause of this violation was related to the cross-cutting areas of problem identification and resolution and human performance, because the licensee did not recognize that the corrective actions taken needed to ensure compliance with NRC requirements.

The issue was determined to be more than minor because the inadequate test acceptance criteria allowed the licensee to accept a check valve as performing its intended function at less than full system flow. The issue was of very low safety significance using the Phase 1 of the significance determination process based on the licensee's determination that the system was operable but degraded. (Section 40A3(3)b.12)

Inspection Report# : [2003010\(pdf\)](#)

Barrier Integrity

Significance:  Feb 19, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

LICENSEE FAILURE TO IDENTIFY LLRT CONFIGURATION NECESSARY TO ADEQUATELY PERFORM TYPE C LEAK TEST FOR NORMALLY OPEN MANUAL ISOLATION VALVES

A finding of very low safety significance was identified by the inspectors for a violation of Technical Specification Containment Leakage Rate Testing Program requirements. The licensee did not adequately perform Type C testing to identify potential leak paths through the bonnet and packing of normally locked opened manual isolation valves associated with containment penetrations for the containment spray system. The primary cause of this violation was related to the cross-cutting area of Human Performance. Licensee personnel, over several operational and test cycles, did not identify and appropriately test the potential leak paths although the licensee identified references in their leakage program, which stated that such testing was needed to comply with regulatory requirements. The issue was more than minor because, if left uncorrected, the issue could become a more significant safety concern because the potential containment leakage path was not being tested in accordance with the requirements for Type C testing. The issue was of very low safety significance because the leakage pathways, when tested, were within acceptable values. The issue was a Non-Cited Violation of Technical Specification 6.16 which required the establishment of a Containment Leakage Rate Testing program as required by 10CFR50.54(o) and 10CFR50, Appendix J.

Inspection Report# : [2005002\(pdf\)](#)

Significance: N/A Aug 09, 2002

Identified By: NRC

Item Type: VIO Violation

I.A - Operating with Reactor Coolant Pressure Boundary Leakage

Technical Specification 3.4.6.2.a, Amendment 220, dated April 14, 1998, requires, in part, that the licensee shall limit reactor coolant system leakage to "No PRESSURE BOUNDARY LEAKAGE" during Modes 1 through 4.

Contrary to the above, between May 18, 2000, and February 16, 2002, the licensee started up and operated the plant in Modes 1 through 4 with reactor coolant system pressure boundary leakage, i.e. control rod drive penetration leakage. Specifically, the licensee returned the plant to operation following the 2000 refueling outages without fully characterizing and eliminating reactor coolant system pressure boundary leakage on the reactor pressure vessel head as evidenced by significant boric acid deposits on the reactor pressure vessel head at the start and end of the outage and by the development of new and extensive boric acid deposits on reactor containment equipment during the operation cycle.

This is a violation associated with a RED SDP finding. Civil Penalty - \$5,000,000 (EA-05-071)

Inspection Report# : [2005012\(pdf\)](#)

Inspection Report# : [2005013\(pdf\)](#)

Significance: SL-I Aug 09, 2002

Identified By: NRC

Item Type: VIO Violation

I.B.1 & 2 - Information Included in (1) CR 2000-1037 and (2) WO 00-001846-000 was not complete and accurate in all material respects.

10 CFR 50.9 requires that information provided to the Commission by a licensee or information required by statute or by the Commission's regulations, orders, or license conditions to be maintained by the licensee shall be complete and accurate in all material respects.

10 CFR 50, Appendix B, Criterion XVI requires, in part, that for significant conditions adverse to quality, the cause of the condition and the corrective actions taken to preclude repetition shall be documented.

10 CFR 50, Appendix B, Criterion XVII, requires, in part, that the licensee shall maintain sufficient records to furnish evidence of activities affecting quality and that those records shall include monitoring of work performance.

Condition Report (CR) 2000-1037, closed May 1, 2000, documented corrective actions for the presence of boric acid on the reactor pressure vessel head, a significant condition adverse to quality, that included: "Accumulated boron deposited between the reactor head and the thermal insulation was removed during the cleaning process performed under W.O. [Work Order] 00-001846-000. No boric acid induced damage to the head surface was noted during the subsequent inspection."

Work Order 00-001846-000, "Clean Boron Accumulation from Top of Reactor Head and Top of Insulation," dated April 25, 2000, required the licensee staff to "clean boron accumulation from top of reactor head and on top of insulation." The Work Order Log, included as Page Four of the completed Work Order, documented that the, "work [was] performed without deviation" and was signed by the System Engineer on April 25, 2000.

Contrary to the above,

1 - The information included in CR 2000-1037 relative to the completed corrective actions and the subsequent inspection results were not complete and accurate in all material respects. Specifically, the licensee did not remove the accumulated boron deposits from all areas between the reactor head and the thermal insulation and did not conduct subsequent inspections of the entire reactor head. Instead, the licensee removed accumulated boric acid deposits from a portion of the reactor vessel head and conducted subsequent inspections for those portions of the reactor vessel head where the boric acid deposits had been removed.

2 - The Work Order Log, included as Page Four of completed Work Order 00-001846-000, a record required by Commission regulations to furnish evidence of activities affecting quality, contained information that was not accurate in all material respects. Specifically, the Work Order Log indicated that boron accumulation was cleaned from the top of the reactor head and on top of the insulation, without deviation, when, in fact, boric acid deposits were left on the head after the cleaning was completed on April 25, 2000.

This is a Severity Level I violation (Supplement VII). Civil Penalty \$110,000 (EA-05-068)

Inspection Report# : [2005013\(pdf\)](#)

Inspection Report# : [2005012\(pdf\)](#)

Significance: SL-II Aug 09, 2002

Identified By: NRC

Item Type: VIO Violation

I.C. 1 & 2 & 3 - Failure to determine the cause of a significant condition adverse to quality involving three examples of identified boric acid leakage.

10 CFR 50, Appendix B, Criterion XVI, requires, in part, that licensees shall establish measures to ensure that conditions adverse to quality such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and non-conformances are promptly identified and corrected. For significant conditions adverse to quality, the licensee shall establish measures to ensure that the cause of the condition is determined and that corrective actions are taken to preclude repetition.

Plant Procedure NG-NA-00702, "Corrective Action Program," Revision 3, defined a significant condition adverse to quality to be a condition, which, if left uncorrected, could have an undesirable effect on plant safety, personal safety, regulatory position, financial liability, or environmental impact.

Contrary to the above, the licensee did not determine the cause of the condition and did not implement corrective actions to preclude repetition of the condition associated with the identification and removal of boric acid on the reactor vessel head, a significant condition adverse to quality, prior to closing the associated condition reports.

Specifically:

1 - On April 27, 2000, the licensee closed CR 2000-0781, "Leakage from CRD [Control Rod Drive] Structure Blocked Visual Exam of Reactor Vessel Head Studs," issued on April 6, 2000, associated with the accumulation of boric acid deposits on the reactor vessel head studs without determining the cause of the deposits, i.e., identifying the source of the reactor coolant system leakage, and without taking corrective actions to preclude recurrence.

2 - On April 27, 2000, the licensee closed CR 2000-0782, "Inspection of Reactor Flange Indicated Boric Acid Leakage From Weep Holes," issued on April 6, 2000, associated with the accumulation of boric acid deposits on the reactor vessel head, without determining the cause of the boric acid deposits, i.e., identifying the source of the reactor coolant system leakage, without removing all of the known boric acid deposits on the reactor pressure vessel head, and without taking corrective actions to prevent recurrence.

3 - On May 1, 2000, the licensee closed CR 2000-1037, "Inspection of Reactor Head Indicated Accumulation of Boron in Area of the CRD [Control Rod Drive] Nozzle Penetration," issued on April 17, 2000, associated with the accumulation of boric acid deposits on the reactor vessel head, without determining the cause of the boric acid deposits, i.e., identifying the source of the reactor coolant system leakage, without removing all of the known boric acid deposits on the reactor vessel head, and without taking corrective actions to prevent recurrence.

This is a Severity Level II violation (Supplement I) Civil Penalty - \$110,000 (EA-05-066)

Inspection Report# : [2005012\(pdf\)](#)

Inspection Report# : [2005013\(pdf\)](#)

Significance: SL-II Aug 09, 2002

Identified By: NRC

Item Type: VIO Violation

I.D - Failure to comply with Boric Acid Control procedure in that obstacles were not removed to allow for a complete inspection of the RPV head (failure to implement mod)

10 CFR 50, Appendix B, Criterion V, requires, in part, that activities affecting quality be accomplished in accordance with written procedures.

Davis-Besse Station Procedure NG-EN-00324, "Boric Acid Corrosion Control Program," Revisions 1/C1 and 2, Step 6.3.1, required, in part, that an initial inspection of boric acid buildup shall be performed to determine the "as found" conditions and to document the inspection results. The procedure also required, in Attachment 3, that insulation and other hindrances to direct visual [inspection] be removed as needed to allow detailed inspections of components suspected of leakage.

Potential Condition Adverse to Quality (PCAQ) 96-0551, initiated on April 21, 1996, documented the licensee's inability to comply with some inspections of the reactor pressure vessel head, as required by Procedure NG-EN-00324, and an inability to accurately determine the reactor pressure vessel head "as found" conditions, associated with boric acid deposits on the reactor pressure vessel head, due to the restrictions resulting from the location and size of the inspection ports, "mouse holes." The PCAQ further documented that only 50 to 60 percent of the reactor pressure vessel head could be inspected using the current inspection ports.

Modification 94-0025, initiated on May 27, 1994, and referenced as corrective action for PCAQ 96-0551, directed the completion of modifications to the reactor pressure vessel head service structure inspection ports to permit the inspection and cleaning of 100 percent of the reactor vessel head in accordance with Procedure NG-EN-00324.

Contrary to the above, on May 18, 2000, and at the end of Refueling Outage 12, the licensee failed to remove obstructions, including boric acid

deposit buildups, necessary to conduct a detailed inspection of the reactor pressure vessel head and other components that may be suspected of leakage, as required by Plant Procedure NG-EN-00324, "Boric Acid Corrosion Control Program." The licensee's ability to conduct the inspections was significantly limited as a result of its concurrent deferral of the installation of Modification 94-0025, a corrective action for a significant condition adverse to quality documented in PCAQ 96-0551 and associated with the licensee's failure during previous outages to conduct complete inspections and cleaning of boric acid deposits on the reactor pressure vessel head.

This is a Severity Level II violation (Supplement I) Civil Penalty \$110,000 (EA-05-067)

Inspection Report# : [2005012\(pdf\)](#)

Inspection Report# : [2005013\(pdf\)](#)

Significance: SL-I Aug 09, 2002

Identified By: NRC

Item Type: VIO Violation

IE1 & 2 - Licensee Responses to Bulletin 2001-01 dated (1) September 4, 2001, and (2) October 17, 2001, were materially incomplete and inaccurate.

10 CFR 50.9 requires that information provided to the Commission by a licensee or information required by statute or by the Commission's regulations, orders, or license conditions to be maintained by the licensee shall be complete and accurate in all material respects.

NRC Bulletin 2001-01, "Circumferential Cracking of Reactor Pressure Vessel Head Penetration Nozzles," required all holders of operating licenses for pressurized water nuclear power reactors to provide information related to the structural integrity of the reactor vessel head penetration (VHP) nozzles for their respective facilities, including the extent of VHP nozzle leakage and cracking that has been found to date, the inspections and repairs that have been undertaken to satisfy applicable regulatory requirements, and the basis for concluding that their plans for future inspections will ensure compliance with applicable regulatory requirements.

Contrary to the above, the licensee, a holder of an operating license for a pressurized water nuclear power reactor, the Davis-Besse Station, provided the Commission responses to Bulletin 2001-01 which included materially inaccurate and incomplete information as follows:

1 - In a September 4, 2001, response to the Bulletin entitled, "Response to Bulletin 2001-01," Serial 2731, the licensee made the following four materially inaccurate and incomplete statements:

(a) The licensee's response to Bulletin Item 1.c, on page 2 of 19, stated: "the minimum gap being at the dome center of the RPV [reactor pressure vessel] head where it is approximately 2 inches, and does not impede a qualified visual inspection."

The licensee's response was materially inaccurate, in that, the statement contradicted statements in the licensee's documents identified as PCAQR 94-0295 and 96-0551, which clearly stated that inspection capability at the top of the reactor vessel head was limited. The limitation was stated to be caused by the restricted access to the area through the service structure "weep holes", the curvature of the reactor pressure vessel head, and by the limited space to manipulate a camera due to the insulation that creates the two inch gap.

(b) The licensee's response to Bulletin Item 1.d, which requested inclusion of a description of any limitations (insulation or other impediments) to accessibility of the bare metal of the reactor pressure vessel head for visual examinations, did not include a description of any limitations.

The licensee's response was materially incomplete in that the response did not mention that accessibility to the bare metal of the reactor pressure vessel head was impeded, during the Eleventh (1998) and the Twelfth (2000) Refueling Outages, by the presence of significant accumulations of boric acid deposits.

(c) The licensee's response to Bulletin Item 1.d, which also requested a discussion of the findings of reactor pressure vessel head inspections, stated that for the Twelfth Refueling Outage (2000), the inspection of the reactor pressure vessel head/nozzles indicated some accumulation of boric acid deposits.

The licensee's response was materially incomplete and inaccurate in that it mischaracterized the accumulation of boric acid on the reactor pressure vessel head and did not mention the evidence of corrosion that was evidenced by the pictures and the video examination of reactor pressure vessel head conditions documented at the beginning and ending of the Twelfth Refueling Outage (2000).

(d) The licensee's response to the Bulletin, on Page 3, stated: "The boric acid deposits were located beneath the leaking flanges with clear evidence of downward flow. No visible evidence of nozzle leakage was detected."

The licensee's response was materially inaccurate in that the boric acid deposits were not all located under leaking flanges and the licensee lacked clear evidence of the absence of downward flow for all nozzles. Specifically, the presence of boric acid deposits was not limited only to the areas beneath the flanges, as implied by that statement. The build-up of boric acid deposits was so significant that the licensee could not inspect all of the nozzles. As a result, the licensee also did not have a basis for stating that no visible evidence of nozzle leakage was detected.

2. In an October 17, 2001, response to the Bulletin entitled, "Supplemental Response to Bulletin 2001-01," Serial 2735, the licensee stated: "In May 1996, during a refueling outage, the RPV [reactor pressure vessel] head was inspected. No leakage was identified, and these results have been recently verified by a re-review of the video tapes obtained from that inspection. The RPV head was mechanically cleaned at the end of the outage. Subsequent inspections of the RPV head in the next two refueling outages (1998 and 2000), also did not identify any leakage in the CRDM [control rod drive mechanism] nozzle-to-head areas that could be inspected. Video tapes taken during these inspections have also been re-reviewed."

The licensee's response was materially inaccurate, in that: (1) each reactor pressure vessel head control rod drive penetration was not inspected in May 1996, as documented in PCAQR 96-0551, and; (2) the reactor pressure vessel head, including the area around each control rod drive penetration, was not completely cleaned, as noted in PCAQR 98-0649, which was prepared at the start of the Eleventh Refueling Outage (1998), which stated that there were old boric acid deposits on the head.

This is a Severity Level I violation (Supplement VII) Civil Penalty \$120,000 (EA-05-072)

Inspection Report# : [2005012\(pdf\)](#)

Inspection Report# : [2005013\(pdf\)](#)

Significance: N/A Aug 09, 2002

Identified By: NRC

Item Type: VIO Violation

II.A 1 & 2 & 3 - Three examples of inadequate corrective actions involving (1) fouling of containmnet air coolers, (2) fouling of containment rad monitors, and (3) increased trend in unident. leakag

10 CFR Part 50, Appendix B, Criterion XVI, requires, in part, that the licensee shall establish measures to ensure that conditions adverse to quality such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and non-conformances are promptly identified and corrected. Criterion XVI also requires that for significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and that corrective actions are taken to preclude repetition.

Plant Procedure NG-NA-00702, "Corrective Action Program," Revision 3, defined a significant condition adverse to quality to be a condition adverse to quality, which, if left uncorrected, could have an undesirable effect on plant safety, personal safety, regulatory position, financial liability, or environmental impact.

Contrary to the above, the licensee failed to determine the root cause of and take corrective actions to preclude the repetition of:

1. Fouling of containment air cooling fins by boric acid, between June 2000 and February 16, 2002, a significant condition adverse to quality.
2. - Fouling of the containment radiation elements by boric acid and iron oxide, between April 2001, and February 16, 2002, a significant condition adverse to quality, and
3. - An increasing trend in unidentified reactor coolant system leakage, between March 2001, and December 2001, a significant condition adverse to quality.

This is a violation associated with a RED SDP finding (EA-03-025).

Inspection Report# : [2005013\(pdf\)](#)

Inspection Report# : [2005012\(pdf\)](#)

Significance: N/A Aug 09, 2002

Identified By: NRC

Item Type: VIO Violation

II.B - Inadequate Boric Acid Corrosion Control procedure.

10 CFR Part 50, Appendix B, Criterion V, requires, in part, that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings.

Procedure NG-EN-00324, "Boric Acid Corrosion Control Program," Revisions 0 through 2 (effective date October 1, 1999), were classified as a procedure affecting quality under the licensee's administrative system.

Contrary to the above, between October 1, 1999, and March 6, 2002, Procedure NG-EN-00324, "Boric Acid Corrosion Control Program," Revisions 0 through 2, were not appropriate to the circumstances and contributed to the licensee's failure to detect and address boric acid corrosion of the reactor vessel head, as follows:

- 1 - The procedure inappropriately focused on bolted and flanged connections in the definition of leakage (Sections 4.2 though 4.4), the definition of reactor coolant system pressure boundary components (Section 4.9), and the identification of investigation locations (Section 6.1) at the expense of identifying the potential for through-wall leakage.
- 2 - The procedure did not include adequate guidance, specifications, or threshold levels for initiating a "detailed inspection" in order to ensure consistent implementation of Section 6.3.4 of the procedure.
- 3 - The procedure did not require the identification of and corrective actions to preclude the repetition of boric acid leaks, a significant condition adverse to quality, but instead only required the preparation of a repair tag or work order to facilitate repair of the leak.
- 4 - The procedure did not define the qualifications and training necessary to permit engineering staff to conduct inspections and evaluations in a consistent manner, including the use of proper inspection techniques, observations, recording of results, and evaluations.
- 5 - The procedure inappropriately exempted stainless steel or Inconel components from further examination related to boric acid corrosion,

unless the examination was during an ASME Section XI test which might require a bolting examination.

6 - The procedure inappropriately did not require the licensee staff to maintain records necessary to demonstrate the proper completion of activities affecting quality.

This is a violation associated with a RED SDP finding (EA-03-025).

Inspection Report# : [2005012\(pdf\)](#)

Inspection Report# : [2005013\(pdf\)](#)

Significance: SL-IV Sep 04, 2001

Identified By: NRC

Item Type: VIO Violation

IID 1 & 2- Two examples of incomplete and inaccurate information contained in quality documents, (1) a void request dated 9/12/93, and (2) a QA Audit Report No. AR-00-OUTAG-01.

10 CFR 50.9 requires that information provided to the Commission by a licensee or information required by statute or by the Commission's regulations, orders, or license conditions to be maintained by the licensee shall be complete and accurate in all material respects.

10 CFR Part 50, Appendix B, Criterion XVII, requires, in part, that the licensee shall maintain sufficient records to furnish evidence of activities affecting quality and that those records shall include audits and those actions taken to correct any deficient conditions.

Contrary to the above, the following information was not complete or accurate in all material respects for documents required to be maintained or provided to the Commission:

1 - On September 23, 1993, the licensee processed a "Document Void Request" to cancel Modification 90-012 which stated, "Current inspection techniques using high-powered cameras preclude the need for inspection ports, additionally, cleaning of the reactor vessel head during last three outages was completed successfully without requiring access ports." However, the quoted statement was not accurate in all material respects, in that, the licensee left boric acid deposits on the reactor vessel head at the end of both the seventh and eighth refueling outages, the two outages preceding this statement.

2 - Quality Assurance Audit Report AR-00-OUTAG-01, dated July 7, 2000, stated, in part, "Boric Acid Corrosion Control Checklists and Condition Reports were initiated by inspectors when prudent to document and evaluate boric acid accumulation and leaks. Boric acid leakage was adequately classified and corrected when appropriate. Engineering displayed noteworthy persistence in ensuring boric acid accumulation from the reactor head was thoroughly cleaned." However, the audit report was not accurate in all material respects in that the licensee did not: 1) thoroughly clean the reactor head during the outage; 2) did not prepare a boric acid corrosion control checklist for the boric acid left on the head after the cleaning attempt; and 3) identify, properly classify, or correct the boric acid accumulation and leaks.

This is a Severity Level IV violation (Supplement VII) (EA-05-070)

Inspection Report# : [2005013\(pdf\)](#)

Inspection Report# : [2005012\(pdf\)](#)

Significance: SL-III Apr 25, 2000

Identified By: NRC

Item Type: VIO Violation

II.C - Two PCAQs (98-0649 & 98-0767) were closed as completed based on inaccurate information.

10 CFR 50.9 requires that information provided to the Commission by a licensee or information required by statute or by the Commission's regulations, orders, or license conditions to be maintained by the licensee shall be complete and accurate in all material respects.

10 CFR Part 50, Appendix B, Criterion XVII, requires, in part, that the licensee shall maintain sufficient records to furnish evidence of activities affecting quality and that those records shall include actions taken to correct any deficient conditions.

Contrary to the above, the following information was not complete or accurate in all material respects for documents required to be maintained or provided to the Commission:

1 - Potential Condition Adverse to Quality Report (PCAQR) 98-0649, dated April 18, 1998, contained the following closure statement: "Accumulation of boric acid on the reactor vessel caused by leaking CRDMs [control rod drive mechanisms] has not resulted in any boric acid corrosion. This was identified through inspections following reactor vessel head cleaning in past outages....Additionally, B&W [Babcock & Wilcox] documentation discussing CRDM nozzle cracking further stated that boric acid deposits on the head caused by leaking CRDM flanges would not result in head corrosion." However, the quoted statements were not accurate in all material respects in that the licensee had previously not cleaned all areas of the reactor head of boric acid deposits, had not inspected the base metal under all the deposits to determine whether corrosion was present, and no B&W documentation was available to support the claim that boric acid would not result in head corrosion.

2 - Potential Condition Adverse to Quality Report (PCAQR) 98-0767, dated April 25, 1998, Section 4A, Item F, included the following closure justification, "The boric acid deposits were removed from the head." However, the quoted statement was not accurate in all material respects in that the licensee had not removed all of the boric acid deposits from the head as of the end of the eleventh refueling outage.

This is a Severity Level III violation (Supplement VII) (EA-05-069)

Inspection Report# : [2005012\(pdf\)](#)

Inspection Report# : [2005013\(pdf\)](#)

Emergency Preparedness

Significance: SL-IV Nov 29, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Submittal of Discrepant ANS PI Data for Second & Third Quarters of 2004

Inspectors identified that the ANS PI data submitted by the licensee for the second and third calendar quarters of 2004 were discrepant. The licensee incorrectly interpreted Revision 2 of the NEI 99-02 that provided criteria on what ANS tests could be counted as PI opportunities. The licensee incorrectly counted its "silent" ANS tests beginning on June 1, 2004 through September 30, 2004. As a result of counting "silent" tests, the reported ANS PI data remained in the GREEN band throughout the 12 month periods ending on June 30 and September 30, 2004. In contrast, NRC concluded that the ANS PI should have been in the WHITE band at the ends of both 12 month periods.

Inspection Report# : [2004018\(pdf\)](#)

Inspection Report# : [2005010\(pdf\)](#)

W

Significance: Nov 29, 2004

Identified By: NRC

Item Type: VIO Violation

Final White Finding - Ottawa County Officials Lost Capability to Activate All EPZ Sirens for About 10 Days & Had Degraded Capability for About 30 Days

The Ottawa County Sheriff Dispatch Center lost its capability to activate all 54 EPZ sirens from April 27 through May 7, 2004, (10 days) and its capability to activate all 54 EPZ sirens was degraded from April 6 through May 7, 2004 (30 days).

The finding was more than minor because if Ottawa County officials needed to promptly activate the EPZ sirens between the morning of April 27 and noontime on May 7, 2004, the EPZ sirens would not have activated and the safety of some of the EPZ population could have been adversely impacted. The preliminary White finding was associated with one of the attributes of the Emergency Preparedness Cornerstone, specifically the facilities and equipment attribute. This preliminary finding was assessed using the Emergency Preparedness SDP and was considered to be a degradation of the risk significant emergency planning standard 10 CFR 50.47(b)(5).

The NRC determined that the final significance of this item was White.

Inspection Report# : [2004018\(pdf\)](#)

Inspection Report# : [2005010\(pdf\)](#)

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Significance: N/A Aug 12, 2005

Identified By: NRC

Item Type: FIN Finding

INSPECTORS CONCLUDED THAT IMPLEMENTATION OF LICENSEE'S CAP WAS SAFE FOR CONTINUED OPERATION

OF THE PLANT

The inspectors concluded that, in general, problems were properly identified, evaluated, and corrected. The licensee was effective at identifying problems and entering them into the corrective action program (CAP) for resolution. The inspectors identified several examples where condition reports were not submitted as required. The weaknesses identified in the past regarding the trending program have shown improvement. As evidenced by the continued large number of condition reports (CRs) entered annually into the CAP, the licensee maintained a low threshold for identifying problems. Generally, the licensee properly prioritized and examined issues; although several minor problems were noted where lower significance issues were mis-categorized or the investigations lacked thoroughness. The formal root cause evaluations for significant problems were thorough and detailed. Corrective actions specified for problems were generally adequate; although, several minor problems were noted where corrective actions were not complete or comprehensive. The licensee's audits and self-assessments were effective in identifying deficiencies in the CAP and recommendations were appropriately captured.

Inspection Report# : [2005014\(pdf\)](#)



Significance: Dec 16, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO FOLLOW CORRECTIVE ACTION PROCEDURE & IMPLEMENT REMEDIATION REQUIREMENTS FOLLOWING REJECTION OF TWO APPARENT CAUSE EVALUATIONS

The inspectors identified a finding of very low significance associated with a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings, for failure to follow the corrective action procedure and implement remediation requirements following rejection of two apparent cause evaluations. This inspector-identified issue was greater than minor because if left uncorrected the issue would become a more significant safety concern involving the implementation of the corrective action program for significant conditions adverse to quality and conditions adverse to quality. The inspectors determined that the finding was not suitable for SDP evaluation because the failure to remediate the evaluators of the condition reports did not directly result in degraded equipment. Therefore, this finding was reviewed by Regional Management, in accordance with IMC 0612 Section 05.04c, and determined to be of very low safety significance. The finding was not greater than very low safety significance because no safety-related equipment was rendered inoperable.

Inspection Report# : [2004017\(pdf\)](#)

Significance: N/A Dec 16, 2004

Identified By: NRC

Item Type: FIN Finding

LICENSEE'S IMPLEMENTATION OF THE CAP WAS SUFFICIENT FOR CONTINUED PLANT OPERATION

The inspectors concluded that implementation of the licensee's corrective action program was safe for continued operation of the plant. Overall, the licensee was effective in identifying and characterizing problems. The significance threshold for entering issues into the program was appropriate. Past weaknesses in the trending program had begun to show improvement. The inspectors identified an example of ineffective problem identification for two occurrences when licensee personnel failed to initiate a condition report for conditions adverse to quality associated with the auxiliary feedwater system.

Inspection Report# : [2004017\(pdf\)](#)

Last modified : November 30, 2005